

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046062

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11143

FILED DEC 5 1963

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN St. Louis, Mo.

Length of stay in 1b

90 year

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1

Inside Limits

Yes ☒ No ☐

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo

b. COUNTY

St. Louis

c. CITY

OR TOWN

St. Louis, Mo

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS

(If outside, give location)

2212 Hickory

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Walker

Smith

4. DATE

OF DEATH

Month

Day

Year

11-

9-

63

## 5. SEX

Male

## 6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

## 8. DATE OF BIRTH

5/5/1900

## 9. AGE (last birthday)

63

## IF UNDER 1 YEAR IF UNDER 24 HR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

## 10b. KIND OF BUSINESS OR INDUSTRY

Common labor

## 11. BIRTHPLACE (City and state or country)

Arkansas

## 12. CITIZEN OF WHAT COUNTRY

U.S.A.

## 13a. FATHER'S NAME

Charlie Smith

## 13b. MOTHER'S MAIDEN NAME

Georgia

## 14. NAME OF HUSBAND OR WIFE

Eddie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Eddie Smith 2212 Hickory

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Acute Renal Failure

## INTERVAL BETWEEN ONSET AND DEATH

4 Days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

## DUE TO (b)

Gram-negative Septicemia

4 Hours

## DUE TO (c)

Traumatic Rupture of Perforation

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Bilateral Bronchopneumonia

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

## 20a. ACCIDENT SUICIDE HOMICIDE

☒ ☐ ☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

undergoing urethroscopy

## 20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

ab. 11-5-63

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Hospital

## 20f. CITY, TOWN, OR LOCATION

St. Louis, Mo.

## COUNTY

## STATE

## 21. I attended the deceased from 11-1-63 to 11-9-63

and last saw her alive on 11-9-63

## Death occurred at 12:40 P

m on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

Herbert H. Shapiro, M.D.

## 22b. ADDRESS

1515 Lafayette Ave.

## 22c. DATE, SIGNED

11-9-63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

## 23b. DATE

11-5-63

## 23c. NAME OF CEMETERY OR CREMATORY

Father Dixon

## 23d. LOCATION (City, town, or county)

Kierwood, Mo

## (State)

## 24. FUNERAL DIRECTOR

A H Burkes

## ADDRESS

3900 Ashland

## 25. DATE RECD. BY LOCAL REG.

NOV 12 1963

## 26. REGISTRAR'S SIGNATURE

Eddie Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

Shapiro  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

OK

Shapiro 11-21-63

Proctor 11-21-63

Photocopy

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *[Signature]*

Licensed Embalmer No. 4622

P. O. Address 1238 N. Kishwaukee

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

-13-